

State Health Plan <i>PPO</i> <i>(does not apply to members represented by MSPTA T-01)</i>		HMO benefits
In-network	Out-of-network	

**Preventive services - \$500 max
for 2003; \$750 max for 2004**

Health maintenance exam	Covered – 100%, one per year up to annual maximum	Not covered	100% covered after \$10 office visit co-payment.
Annual Gynecological Exam	Covered - 100%, one per calendar year up to annual maximum	Not covered	100% covered after \$10 office visit co-payment
Pap smear screening – laboratory services only *	Covered – 100%, one per year up to annual maximum	Not covered	100% covered after \$10 office visit co-payment
Well-baby and child care	Covered – 100% up to annual maximum	Not covered	100% covered after \$10 office visit co-payment
Immunizations, annual flu shot and Hepatitis C screening for those at risk	Covered – 100% up to annual maximum	Not covered	100% covered after \$10 office visit co-payment
Fecal occult blood screening *	Covered – 100% up to annual maximum	Not covered	100% covered after \$10 office visit co-payment
Flexible Sigmoidoscopy *	Covered - 100% up to annual maximum	Not covered	100% covered after \$10 office visit co-payment
Colonoscopy *	Covered - 100% up to annual maximum	Not covered	100% covered after \$10 office visit co-payment
Prostate specific antigen screening *	Covered – 100% one per year up to annual maximum	Not covered	100% covered after \$10 office visit co-payment

Mammography *

Annual standard film mammography screening (covers digital mammography up to the standard film rate)	Covered – 100%	Covered 90% after deductible	Covered – 100%
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Physician office services

Office visits, consultations & urgent care visits	Covered – \$10 co-pay	Covered 90% after deductible	\$10 co-payment.
Outpatient and home visits	Covered – 100% after deductible		

* American Cancer Society guidelines apply

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Emergency medical care

Hospital emergency room-for medical emergency or accidental injury	Covered – 100%	\$50 co-payment, if not admitted
Ambulance services – medically necessary	Covered – 100% after deductible	Covered – 100%

Diagnostic services

Laboratory and pathology tests	Covered – 100% after deductible	Covered – 90% after deductible	Covered – 100%
Diagnostic tests and x-rays			
Radiation therapy			

Maternity services – (includes care by a certified nurse midwife)

Pre-natal and post-natal care	Covered – 100% after deductible	Covered – 90% after deductible	Office visit: \$10 co-payment.
Delivery and nursery care			Covered – 100%

Hospital care

Semi-private room, inpatient physician care, general nursing care, hospital services and supplies	Covered – 100% after deductible, unlimited days	Covered – 90% after deductible, unlimited days	Covered – 100%, unlimited days
Inpatient consultations	Covered – 100% after deductible	Covered – 90% after deductible	Covered – 100%
Chemotherapy			

Alternatives to hospital care

Skilled nursing care- up to 120 days per confinement (730 days for UAW and MSPTA)	Covered – 100% after deductible	Covered – 100% after deductible	Check with HMO
Hospice care	Covered – 100% Limited to the lifetime dollar maximum that is adjusted annually by the state		Covered – 100%
Home health care	Covered – 100% after deductible, unlimited visits		

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Surgical services

Surgery – includes related surgical services	Covered – 100% after deductible	Covered – 90% after deductible	Covered – 100%
Voluntary sterilization			Covered – 100%

Human organ transplants

Liver, heart, lung, pancreas and other specified organ transplants - covered in designated facilities only	Covered – 100% in designated facilities only. Up to \$1 million lifetime maximum for each organ transplant	Covered – 100%, in designated facilities
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Organ and tissue transplants

Bone marrow — specific criteria apply	Covered – 100% after deductible	Covered – 90% after deductible	Covered – 100% in designated facilities
Kidney, cornea and skin			Covered – 100%, subject to medical criteria

Other services

Allergy testing and injections	Covered – 100% after deductible	Covered – 90% after deductible	Office visits: \$10 co-payment; Injections: 100% covered.
Acupuncture	Covered - 90% after deductible if performed by or under the supervision of a M.D. or D.O.		Check with your HMO
Rabies treatment after initial emergency room visit	Covered – 100% after deductible	Covered – 90% after deductible	Office visit: \$10 co-payment. Injections: 100% covered.
Chiropractic/spinal manipulation	Covered – 90% after deductible Up to 24 visits per calendar year		Check with your HMO
Durable medical equipment	Covered – 90% after deductible		Covered 100%
Prosthetic and orthotic appliances			
Private duty nursing			
Wig, wig stand, adhesives	Upon meeting medical conditions, eligible for a lifetime maximum reimbursement of \$300. (Additional wigs covered for children due to growth.)		Check with your HMO.

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Outpatient physical, speech and occupational therapy (combined maximum of 60 visits per calendar year)

Outpatient physical, speech & occupational therapy – facility and clinic services	Covered – 100% after deductible		Covered 100%
Outpatient physical therapy - physician's office	Covered – 100% after deductible	Covered –90% after deductible	Office visit: \$10 co-payment

Deductible, co-pays and out-of-pocket dollar maximums

Deductible	\$200 per member \$400 per family	\$500 per member, \$1,000 per family	None
Co-pays • Fixed dollar co-pays	\$10 for office visits, office consultations, urgent care visits, osteopathic manipulations and medical hearing exams	Not applicable, but deductible and co-pay apply	\$10 for office visits \$50 for emergency room visits, if not admitted
• Percent co-pays	10% for DME, prosthetic & orthotic appliances, private duty nursing, chiropractic manipulation and, acupuncture	10% for most services	None
Annual out-of-pocket dollar maximums ¹	\$1,000 per member/ \$2,000 per family	\$2,000 per member \$4,000 per family	None

¹ The out-of-pocket limit does not apply to member co-payments for chiropractic.

Please see Section 4 of the booklet regarding Mental Health/Substance Abuse and prescription drug benefits.

DISCLAIMER: This is intended as an easy-to-read summary. It is not a contract. Additional limitations and exclusions may apply to covered services. Payment amounts are based on the Blue Cross Blue Shield of Michigan approved amount, less any applicable deductible and/or co-pay amounts required by the State Health Plan PPO. This coverage is provided pursuant to a contract entered into in the State of Michigan and shall be construed under the jurisdiction and according to the laws of the State of Michigan.